2019

BABY YOUR BABY *Training*

UTAH DEPARTMENT OF HEALTH MEDICAID
A Bridge to Wellness for Utah's Vulnerable

BABY YOUR BABY

Through the Baby Your Baby program, medical assistance is available on a temporary basis for pregnant Utah women to help pay for prenatal care.

State of Utah

November 2019

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PART 1 General Information

Section 1: What is Baby Your Baby (BYB)

- BYB is temporary Medicaid coverage for pregnant women determined presumptively eligible by a qualified BYB Provider.
- The Utah Department of Health (DOH) issues Memorandum of Agreements between DOH and qualified BYB providers throughout the state to administer the program. Only BYB providers who are trained on the BYB process can determine BYB eligibility.
- The BYB program is managed and facilitated by two departments: DOH and Department of Workforce Services (DWS).
    - Two areas within DOH help to manage and facilitate the program:
        - The Bureau of Eligibility Policy oversees BYB policy, procedures, accuracy of the BYB program and acts as a resource to qualified BYB Providers for training, education, and eligibility related questions or issues.
        - The Bureau of Health Promotion manages the BYB Hotline (1-800-826-9662) and determines eligibility on BYB applications that are received through the hotline. They also provide outreach to the public regarding the importance of early, continuous and quality prenatal care.
    - DWS enters all BYB decisions received from qualified BYB Providers into the eligibility system. DWS then uses the BYB application to determine ongoing Medicaid eligibility and stores all BYB applications received.

Section 2: Contact Information

Laura Belgique
Program Specialist
Email: bybpolicy@utah.gov
Phone: (801) 538-6241
Fax: (801) 538-6952
Utah Department of Health, Medicaid and Health Financing
PO Box 143107
Salt Lake City, UT 84114-3107

OR

Dave Baldwin
Program Specialist
Email: bybpolicy@utah.gov
Phone: (801) 538-7020
Fax: (801) 538-6952
Utah Department of Health, Medicaid and Health Financing
PO Box 143107
Salt Lake City, UT 84114-3107

Section 3: Resources

- For questions regarding eligibility, policy and procedure or to request training, email bybpolicy@utah.gov.
- For Baby Your Baby Hotline information contact:
  Marie Nagata
  BYB Hotline Manager
  Utah Department of Health
  PO Box 142106
  Salt Lake City, UT 84114-2106
  Personal email: mnagata@utah.gov
  Phone: (801) 538-6519
  Fax: (801) 323-1577

❖ To order BYB applications and related material including Keepsakes, call 800-826-9662 or online at: http://www.babyyourbaby.org/order-materials/

❖ For questions regarding covered services, medical billing/payment, call Medicaid at: (801) 538-6155 or 1-800-662-9651.

❖ Unless you approve the BYB application online via PEP, fax or email all complete BYB applications to:
  Department of Workforce Services
  Fax: (801) 526-4399 or toll-free 1(800) 395-8999
  Email: pe-baby@utah.gov
  Note: Send applications to DWS within five business days from the date of the BYB determination.

❖ To verify client eligibility:
  - Access the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility or
  - Call Medicaid at (801)538-6155 or 1-800-662-9651.
    - Enter the client ID number and use the BYB determination date as the date of the medical service received. If the client is eligible, the system will give the medical program type, health plan, co-pay, mental health coverage information, and third party liability information.

PART 2 Policies and Procedures

Section 1: Terms of Agreement

- A BYB Provider must agree to follow the State's policies and procedures. DOH will provide BYB Providers with information on all policies and procedures related to BYB.
- DOH will monitor BYB Provider's BYB determinations. If a BYB Provider is not making BYB determinations in accordance with DOH's policies and procedures, DOH will provide the BYB Provider with additional training or other forms of corrective action before disqualifying the BYB Provider. Performance standards require BYB Providers to achieve an accuracy rate of at least 85% of the BYB decisions made. Accuracy is measured by how accurate the determinations are based on the information provided by the client.
- All BYB Provider's must have a Memorandum of Agreement (MOA) with DOH.
- All BYB Providers must be trained by DOH on the BYB process before determining BYB eligibility. Training conducted by fellow staff does not meet this requirement.
- All BYB Providers must notify DOH when a new staff member is hired to determine BYB eligibility. DOH will schedule and provide training accordingly.
- All BYB Providers must notify DOH within five business days when any staff changes job responsibilities or terminates employment.
- All BYB Providers are required to check current Medicaid eligibility for all BYB applicants prior to making an eligibility decision.
- Any BYB Provider who applies for BYB coverage cannot process (approve or deny) their own application.

Section 2: Services and Payment

- BYB covers Medicaid eligible, pregnancy-related services provided by any Utah Medicaid Provider including pharmacy and dental. This includes prenatal visits, prenatal lab tests, ultrasounds, prenatal vitamins. **It does not cover the delivery of the baby**.
- BYB Providers will be paid at regular Medicaid rates for covered services.

Section 3: Confidentiality

- All confidential information must be safeguarded from unauthorized disclosure and use. Staff who fail to safeguard confidential information may be subject to both civil and criminal penalties.
- Confidential information includes:
  - Identifying information, such as names, addresses, telephone numbers, social security numbers, etc.
  - Information used to determine eligibility, such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc.

- Information about benefits and medical services provided to individual clients.

- Information that cannot be identified to particular applicants and clients is not confidential information. For example, information stating the total number of BYB clients is not confidential information because no one person can be identified by the general information.
- The hospital shall only access, use, or disclose data solely for the purposes of determining BYB.
- The hospital shall implement and maintain administrative, technical, and physical safeguards necessary to protect the confidentiality of the data and to prevent any unauthorized use or access. Any and all transmission or exchange of data and electronic records must take place via secure means.

Section 4: Fraud, Waste and Abuse

- To report suspected fraud, contact the DWS Information Fraud Hotline at 1-800-955-2210 or via email at wsinv@utah.gov
- When reporting fraud, waste or abuse:
  - Provide any of the following information:
    - BYB Provider, Medicaid Provider or client name
    - Date of birth
    - Address
    - Phone number
    - Medicaid ID or SSN
    - Other details about what you suspect may be happening that appears to be wrong
  - You may remain anonymous when reporting suspected fraud.
  - You may be requested to provide your name so that the investigator can contact you if there are questions regarding your referral. However, you may request that your name is not used in conjunction with the case.
- For more information on reporting fraud, waste or abuse, visit: http://health.utah.gov/mpi/recipient.html

Section 5: Completing the 61 MED (BYB Paper Application)

- Always use the most current application form. DOH will supply hospitals with applications and determination forms. These are the applications that must be used. BYB providers may **NOT** create their own application.
- The application serves as both a BYB application and an ongoing Medicaid application.
- Applying for ongoing Medicaid benefits is not a requirement for BYB. If the client chooses not to apply for ongoing benefits, they may opt-out of this service by checking the box on page 8 of the application (Section K, question 8).

- Self-declaration is used for all factors of eligibility, including pregnancy.
- Only four BYB specific sections must be completed to determine BYB. We encourage clients to complete additional sections, or the entire application if they wish.
- The following sections of the application must be completed in order for BYB to be determined:

  Page 1:
  - Section A: Name, Address, Phone number
  - Section B: Question 1 Only

  Page 2:
  - Section C: Questions 1 and 9

  Page 8:
  - Section K: All except question 6

  Page 10:
  - Section L: Signature

- Clients can apply for BYB through any BYB site, the BYB hotline, or online through the Presumptive Eligibility Portal at medicaid.utah.gov/peportal
- Pregnant minors (under the age of 18)
  - A parent, legal guardian or representative must complete and sign the BYB application on behalf of a pregnant minor unless she is living independently.
  - If an applicant is between the ages of 18 and 19 and living with a parent, legal guardian or representative, she can apply (and sign) an application her own behalf.
- Review all questions on the application before making a determination.
- If the client is approved for BYB, the start date for eligibility is the date the application is approved by the BYB Provider.
- If the client has answered the application questions and you therefore have the information you need to make an eligibility determination, use that information to make a determination as soon as possible, even if you have not talked to the client. An interview is not required.
- If you do not have enough information to make an eligibility determination and are unable to talk to the client , deny BYB after 30 calendar days from the application date. Do not leave it in pending status beyond this period. If the 30th day is a non-business day, you have until the following business day to make a decision.
- Complete and immediately provide the client the Presumptive Eligibility Receipt once the determination is completed.
- Individuals can still receive BYB if they have other health insurance.
- If the client does not have a SSN or refuses to provide the SSN, the field can be left blank. Although the SSN is not required, it should be requested from the client as it allows for efficient processing of her application.

- In order to be considered for BYB, a client must submit the application to a BYB Provider. If a client completes only the BYB-required sections of the 61MED and submits to DWS instead of a BYB Provider, DWS will use that application to determine full Medicaid and not BYB.

Section 6: Eligibility Criteria

Compare the responses on the application to the eligibility criteria listed in this section. Individuals who do not meet the criteria listed below are not eligible for BYB. Remember that self-declaration is used for all eligibility criteria.

- Be a U.S. Citizen, U.S. National, or a qualified non-citizen
  - U.S. Citizens are individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands.
  - U.S. Nationals are individuals born in American Samoa or Swain's Islands
  - Qualified non-citizens are individuals who are lawfully admitted into the U.S.
    - Certain individuals who entered the country after August 22, 1996 are barred from receiving BYB for five years after the date they became a qualified non-citizen. The five year bar does not include children under the age of 19 who are a qualified non-citizen or lawfully present.
    - Refer to Medicaid policy section 205-2 for a complete list and definitions of qualified non-citizen and statuses that are barred for the 5 years.
    - Refer to Medicaid policy section 205-2.1 for more information on lawfully present children under age 19.
    - Medicaid manual: https://bepmanuals.health.utah.gov/Medicaidpolicy/DOHMedicaid.htm

    Note: Individuals from the Marshall Islands and Deferred Action for Childhood Arrivals (DACA or dreamers) are **not** eligible for BYB.
- Be a Utah resident.
- Must not have received BYB or Hospital Presumptive Eligibilty (HPE) for the current pregnancy.
- Must not currently be receiving Utah Medicaid, CHIP, UPP or HPE or Medicaid with a spenddown, even if the spenddown has not been paid. **Note: Medicaid eligibility must be checked on all applicants prior to making a determination. See Appendix E for information on how to check eligibility.**
- Must not have received a denial for Medicaid, CHIP or UPP within the past 30 days, unless household circumstances have changed. **For example,** if the client was denied for Medicaid because her income was too high and now reports that her income has changed; determine if the client is eligible for BYB.
- Has a gross household income at or below the income level for her household size. See section 8 on how to determine household size and section 9 for income information.
- There is no asset test

Section 7: Determining Household Size

- Refer to Question 1, Section B (page 2) of the application to determine who needs to be included in the household size. Household size is determined by relationship and living arrangements. Do not include individuals who do not live in the same household. Use the chart below to determine household size.
- For joint custody situations, count a child residing in a parent's home if the client states the child resides in the home at least 50% of the time.

Household Size Chart: Only include individuals living together (in the same household)

19 or older Include:	19 or under Include:
Individual	Individual
Individual's legal spouse (not boyfriend)	Individual's legal spouse (not boyfriend)
Individual's unborn child(ren)	Individual's unborn child(ren)
Individual's child(ren) under age 19	Individual's child(ren) under age 19
Individual's step-child(ren) under age 19	Individual's step-child(ren) under age 19
	Individual's parent(s) or step-parent(s)
	Individual's siblings under age 19

Household Size Exercise #1 Mary is single, 17 years old and pregnant with her first baby. She lives with her boyfriend in her parent's home, along with 2 younger sisters, ages 15 and 13. What is the total household size?

Household Member	Counted in Household?
Mary	Yes
Unborn	Yes
Boyfriend	No
Mary's mom	Yes
Mary's dad	Yes
Sister #1	Yes
Sister #2	Yes

In this case, Mary, the unborn, both of Mary's parents (as she is a minor) and both siblings are counted as part of the household. The household size is 6.

Household Size Exercise #2 Amy is 16 and pregnant with her first child. She lives with her boyfriend at the home of one of his friends. What is the total household size?

Household Member	Counted in Household?
Amy	Yes
Unborn	Yes
Boyfriend	No

Friend	No

In this case, Amy and the unborn are counted in the household. The total household size is 2.

Section 8: Income

❖ General Rules

- Income is cash (checks, direct deposits, etc.) or unearned income.
- For earned income, count the gross amount (before taxes and deductions) of everyone included in the household size.
- For self-employment, count the net income after business expenses.
- Unearned income
  - Unearned income is cash (checks, direct deposits, etc.) or in-kind benefits received by an individual for which a person performs no service.
  - Examples of unearned income:
    - Pensions and annuities
    - Disability benefits such as social security disability insurance, workers compensation, long-term disability insurance from an employer, and paycheck insurance.
    - Survivor benefits such as Social Security, Railroad Retirement.
    - Unemployment compensation; strike and union benefits
    - Rental income, sales contracts, inheritances, life insurance benefits, personal injury settlements, medical insurance payments, cash gifts.
- The income of a child who is under age 19:
  - Is not countable if the child is living with a parent
  - Is countable if the child is not living with a parent
- For American Indian/Alaskan Native, count wages from employment, revenues from tribal run gambling, and unearned income such as Social Security or Unemployment benefits. All other tribal income is exempt.
- Exempt income:
  - Educational income
  - Veteran's income
  - Child support
  - Do not count the income of a child to another child (sibling)
  - Do not count the income of a child to a parent
  - Do not count the income of a guardian to the child(ren)
- Compare the gross income to the current income limit for the household size. If she is at or below the income limit, she meets the income requirement.
  Note: income guidelines may change yearly. DOH will email BYB Providers with an updated income chart each year. Make sure to use the most recent version. See appendix G for the current income chart.

Determining Income

If the client needs assistance to determine their income, follow the steps below.

❖ Determining Income Without Check Stubs

To determine monthly income without check stubs, you need to know how often the individual is paid, how many hours a week they work and their hourly rate.

- **Paid "Weekly" or "Every Other Week"**
  - Multiply hours worked each week by the hourly rate. This will give gross weekly income.
  - Multiply gross weekly income by 4.3. This will give the gross monthly income.

  Example: Individual works 32 hours a week at $11.25 an hour.
  - 32 hours per week 'X' $11.25 an hour = $360 (weekly income).
  - $360 'X' 4.3 = $1548 (monthly income).
- **Paid "Twice a Month" or "Monthly"**
  - Use the 172 hour chart (appendix C)
    - Find the weekly hours the individual states they work in the left column. This will determine the monthly hours as shown in the right column.
    - Multiply the monthly hours by the hourly rate. This will give you their gross monthly income.

  Example: Individual works 29 hours a week at $10.25 an hour.
  - 29 weekly hours = 126 monthly hours.
  - 126 monthly hours 'X' $10.25 = $1,291.50 (monthly income)

❖ Determining Income Using Check Stubs

Check stubs are not required. However, if an applicant provides you with check stubs, determine income as follows:

- **Paid "Weekly"**
  - Multiply gross amount on the check stub by 4.3.
  - Check stub shows gross income of $512.50. Multiply $512.50 by 4.3 = $2203.75 (monthly income).
- **Paid "Every Two Weeks"**
  - Multiply the gross paycheck amount by 2.15
  - Check stub shows gross income of $412.55. Multiply $412.55 by 2.15 = $886.98 (monthly income).
- **Paid "Twice a Month"**

- Multiply the gross paycheck amount by 2.
- Check stub shows gross income of $680.01. Multiply $680.01 by 2 = $1360.02 (monthly income).

➢ **Paid "Monthly"**

- The gross amount on check is the gross monthly income.

Section 9: What Happens Next After an Eligibility Determination?

☑ Complete the Presumptive Eligibility Determintion form (cover page) for all approved and denied applications. Make sure to complete all fields and include the denial reason if the applicant in not eligible.

Denial reasons are as follows:

1. **Not a U.S. citizen or eligible non-citizen**
2. **Not a Utah resident**
3. **Current CHIP, UPP or Medicaid client**
4. **Medicaid denial in the past 30 days**
5. **Already received HPE or Baby Your Baby (BYB) for the current pregnancy**
6. **Over the income limit**
7. **Not pregnant**

☑ Send pages 1-10 of ALL applications (approved and denied) along with a cover page to DWS **via email: pe-baby@utah.gov or by fax: (801) 526-4399** within five days from the date of determination.

☑ Immediately provide a copy of the PE Determination Receipt to the client.

☑ Important:

- Do NOT just submit the BYB required sections/pages.
- Do **NOT** fax the application to the number listed on the application**.** If you do, BYB cannot be approved.
- Attachments A-D (pages 11-21) are to be given to the client. Do not send these pages to DWS.
- Please ensure each page of the application faces the same way before emailing or faxing to DWS.
- Only submit one application per email or fax.
- Shred the paper application after sending to DWS.
- Scanning then emailing is the preferrrred method of sending applications to DWS. Send applications through a secured/encrypted process.

☑ Additional information on all applications:

- DWS will enter the BYB decision into the eligibility system within one or two days from the date you submit the application. DWS will send the approval/denial notice and medical card (if approved for BYB). DWS will then use the application to determine ongoing Medicaid eligibility, unless the client opts-out.
- BYB coverage will continue until DWS makes a decision for ongoing Medicaid. The day the decision is made for ongoing Medicaid (approved or denied) is the same day the BYB program will end.

- If the client opted out for ongoing Medicaid, BYB coverage will end on the last day of the following month BYB was approved.

- BYB eligibilty will be added to a wallet-sized Medical Identification Card. If aclient has not received a Medical Identification Card or states she needs this card, one will be mailed out to the client through the eligibility system. Replacement cards will be issued upon request if the card is lost or damaged. See Appendix B for a sample of the Medical Information Card.
- The client will not receive another card if she becomes eligible for ongoing Medicaid. The client will continue to use the card issued for BYB.
- DWS will deny a BYB Provider's decision if the individual is currently receiving Medicaid, CHIP, UPP or Medicaid with a spenddown, even if the spenddown has not been paid.

Section 10: Education

Educate the client on the following:

***Note:** The education is an important part of BYB. However, do not delay making an eligibility determination in order to provide the information listed below. This education can be provided after a determination has been made.*

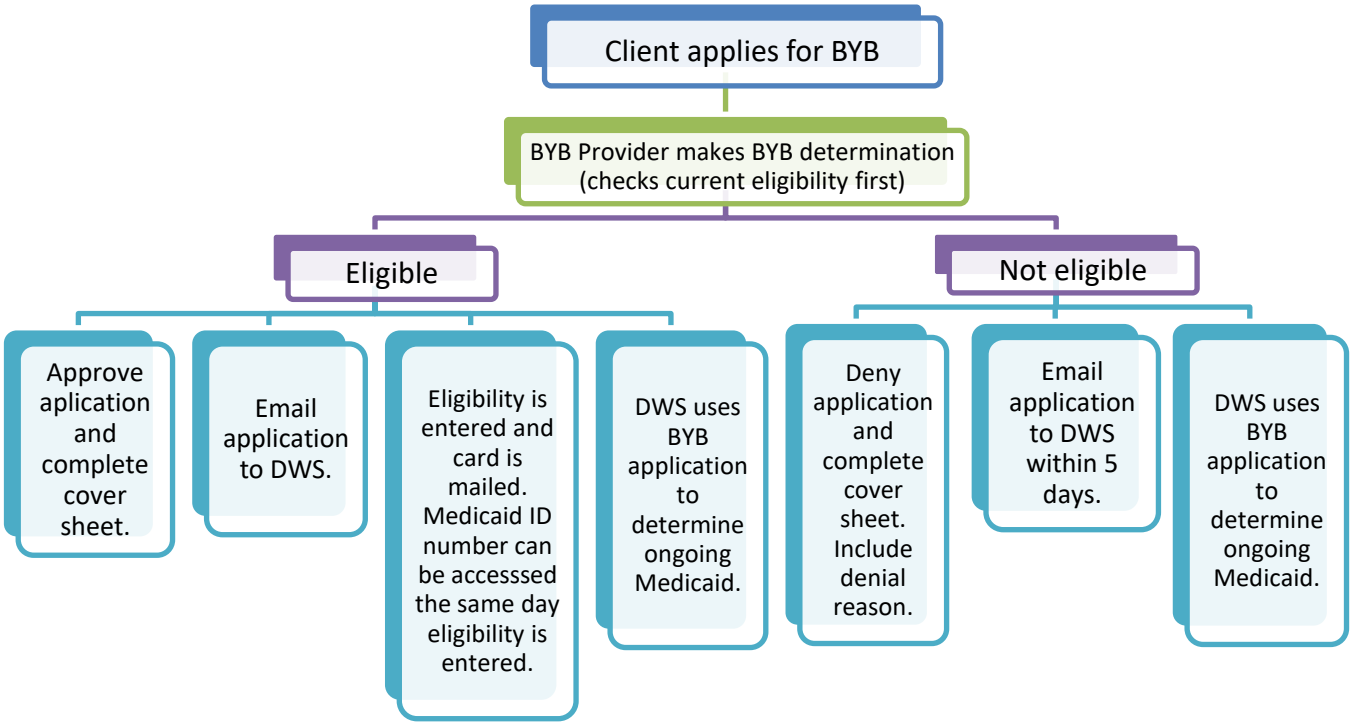
- ☑ Inform the client the application will be forwarded to DWS who will determine continued Medicaid eligibility.
- ☑ Inform the client that she will receive a BYB card by mail.
- ☑ Inform the client if she is approved for ongoing Medicaid, she will continue to use the same wallet-sized card that was issued for BYB. Question #1 in Section C of the application is where the client indicates whether or not they need a new card. If they still have a medical card in their possession from eligibility they received in the past, they should answer "no" to this question.
- ☑ Inform the client they can use their BYB eligibilty with any Utah Medicaid Provider.
- ☑ Educate the client on covered services. BYB covers only pregnancy related outpatient services. Labor and delivery are not covered.
- ☑ Inform the client to stop using BYB benefits if they are denied for ongoing Medicaid.
  - If the client continues to use BYB eligibility after being denied for ongoing medical assistance, she may be responsible to pay back any benefits received.
- ☑ Inform the client that she can only receive BYB once per pregnancy.

Check List:

- ☑ Make sure all BYB-specific sections of the application are complete. Encourage clients to complete additional sections, or the entire application.
- ☑ Check current Medicaid eligibility on all applicants prior to making a determination.

- ☑ Complete the Presumptive Eligibility Determination Form.
- ☑ Send the entire application to pe-baby@utah.gov within five business days. This includes both approved and denied applications.
- ☑ Shred the paper application.

Section 11: Paper Application Process Flow Chart



PART 3 Presumptive Eligibility Portal (PEP)

Section 1: What is the Presumptive Eligibility Portal (PEP)?

- PEP is a comprehensive application system that provides the following features:
  - Ability for clients to apply online: https://medicaid.utah.gov/byb-info
    - Application available in both English and Spanish
  - Application serves as both a BYB application and an ongoing Medicaid application (unless the client opts out)
  - Ability for BYB Providers to help a client complete an application. The client must electronically sign and date the application (in person) or if completed over the phone, the client must electronically sign and return the signature to the BYB Provider via email.
  - Ability for BYB Providers to process applications received through PEP.

Section 2: Access to PEP

To obtain access to PEP:

1. Contact the BYB Program Specialist (bybpolicy@utah.gov) to request access to PEP. The following information must be included with your email request:
   - BYB Provider contact information (name, phone number and email)
   - Location
   - Date the BYB Provider will begin processing BYB applications on PEP.
2. The program specialist will then provide you training on PEP.
3. After completing the training, you will go through a registration process by creating a user name (your email) and a password, then selecting your office/BYB site. You will then receive an email confirming your registration, asking to verify your registration information. UDOH will then approve your access at which point you will receive an enrollment approval email.
4. Once your account has been activated, you can manage BYB applications by logging in at: https://peportal.medicaid.utah.gov/PEPProviderAdmin
   - You will be required to check your PEP account on a regular basis to ensure you are processing the applications. Remember that BYB eligibilty starts on the date that you make an approval determination, not the application date. Clients will lose out on needed eligibility if you have enough information to process but delay the processing.
5. If you no longer work with BYB, contact the program specialist immediately to close your PEP account.
6. If you see other BYB Providers listed on PEP and they no long administer BYB, contact the program specialist immediately to remove their names.

Section 3: Summary of PEP Process

1. The primary BYB Provider(s) at each site receive an email when an application is sent to their queue.
2. While logged into to PEP, a BYB Provider also has ability to help a client complete an application. The client must electronically sign the application (in person) or if completed over

the phone, have the client electronically sign and return the signature to the BYB Provider via email.

3. BYB Provider views list of all pending applications assigned to BYB site.
4. BYB Provider reviews application.
5. BYB Provider checks current Medicaid eligibility for all BYB applicants.
   - Use the Provider Lookup Tool or call the Medicaid hotline to verify eligibility. See appendix E for more information.
6. BYB Provider makes eligibility decision.
7. DWS receives information and enters BYB Provider's decision into the eligibility system (do not submit a Presumptive Eligibility Determination form as required with paper applications).
8. DWS processes ongoing application (unless applicant opts out) and notifies applicant of decision.

Section 4: Confidentiality

- The same confidentiality and release of information requirements mentioned in Part 2, Section 3 apply to PEP.
- When you are working in the system, SIGN OUT if you leave your desk at any time. You must maintain strict protection and confidentiality of the information in the system. Do NOT share your password with anyone else including co-workers. If a co-worker or anyone else needs access to PEP, that individual needs to set up his own account.
- Do not email any client identifying information, including Social Security Numbers.

PART 4 Appendices

Appendix A: Sections of the 61MED which must be completed in order for BYB to be determined. Required fields are highlighted.

- First Section: (Page 1 of application)

DOH 61MED 05/01/2017

APPLICATION

DO3417600010121

A APPLICANT INFORMATION

Name: _____
first (start with yourself) middle initial maiden last

Home Address: _____
(leave blank if you don't have one) street apt.# city state zip

Mailing Address: _____
(if different from home address) street apt.# city state zip

Home Phone: (_____)_____ or Cell/Other Phone: (_____)_____

E-mail (optional): _____

☐Yes ☐No Do you speak English? If no, what is your primary language? _____

Would you like to receive notices in English or Spanish? ☐English ☐Spanish

B HOUSEHOLD INFORMATION

1. List everyone who is living in your household. Check the box for those applying for health coverage.

Name (first, m.i., last) ☑ Check box if applying for coverage.	Relation to You	[1]Social Security#	Birth Date (mm/dd/yy)	Sex (f/m)	[2]Race	[3]Ethnicity	[4]Marital Status	Full Time Student (y/n)	Utah Resident [1]U.S. Citizen/ National Eligible Non-Citizen
☒ Pregnant mom	Self								☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐ List all other individuals in the household (living together)									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐ Check box if that individual wants DWS to look at ongoing medical assistance.									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen

[1]Social Security Number & Citizenship: Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. SSN is not required for people applying for presumptive eligibility. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

[2]Race Codes (Optional): **WH:** White, **BL:** Black/African American, **AI:** American Indian/Alaska Native, **ASI:** Asian Indian, **CH:** Chinese, **FI:** Filipino, **JA:** Japanese, **KO:** Korean, **VI:** Vietnamese, **OA:** Other Asian, **NH:** Native Hawaiian, **SA:** Samoan, **GC:** Guamanian/Chamorro, **OPI:** Other Pacific Islander, **OT:** Other

[3]Ethnicity Codes (Optional): **N:** Not Hispanic/Latino, **M:** Mexican, **MA:** Mexican American, **CH:** Chicano/a, **PR:** Puerto Rican, **CU:** Cuban, **AH:** Another Hispanic, Latino, or Spanish Origin, **OT:** Other

[4]Marital Status: Single, Married, Divorced, Widowed

1

Appendix A, continued:

- Second Section (Page 2 of application)

B HOUSEHOLD INFORMATION (CONT.)

D03417000010221

2. If you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits.
3. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below.

Name	Immigration Document Type	Alien or I-94#	Document ID# *(if different from Alien#)*	Lived in the U.S. Since 1996? (y/n)	Is a veteran or an an active-duty member of the U.S. military, or has spouse or parent who is (y/n)

C GENERAL INFORMATION

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical benefits have a Utah Medicaid card *(This card is used for both Medicaid and PCN)*?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____ For which month(s):_____

☐Yes ☐No 3. Do you want help paying for COBRA or your employer's health insurance plan?

☐Yes ☐No 4. Does anyone who is applying for coverage have a major medical need? This includes cancer, kidney disease, heart disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 5. Are you the primary person taking care of a child living in your home under age 19?

☐Yes ☐No 6. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday?
If yes, who:_____
Did he/she receive Medicaid at that time? ☐Yes ☐No

☐Yes ☐No 7. Does anyone who is applying for coverage have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 8. Is anyone who is applying for coverage living in an institution (such as a hospital, nursing home, jail, or prison)?
If yes, who: _____ When:_____ How long: _____

☐Yes ☐No 9. Is anyone who is applying for coverage currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____ Due date:_____
How many babies are expected during the pregnancy? _____
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco cessation programs. Response to this question is optional.)

☐Yes ☐No 10. Does any child who is applying for coverage have a parent living outside the home?
If yes, are you willing to cooperate with the Office of Recovery Services to establish medical support from an absent parent(s)? ☐Yes ☐No

2

- Third Section (Page 8 of application):

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE) & BABY YOUR BABY (BYB)

D03417800010821

If there is anyone in your household who is applying for HPE or BYB, you are required to answer questions on this page in addition to the specified questions on page 1 and 2. Please refer to the Application Information coversheet to identify which specific questions on page 1 and 2 you must answer. Make sure you sign the application on page 10.

K HPE AND BYB QUESTIONS

☐Yes ☐No 1. Does anyone in your household have earned or unearned income?
Enter total monthly household earned income before taxes. $_____ (must complete.)
Enter total unearned income your household receives each month. $_____ must complete

☐Yes ☐No 2. Is anyone in your household who is applying for benefits, but is not a U.S. Citizen or National, an eligible non-citizen? If yes, complete the chart below.

Applicant's Name	Eligible Non-Citizen Status	Date Granted Status (month/year)

☐Yes ☐No 3. Is anyone in the household currently on Utah Medicaid, CHIP, PCN, UPP, BYB, HPE, or has been approved for Utah Medicaid with a spenddown?
If yes, who: _____

☐Yes ☐No 4. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, who: _____
If yes, what household circumstances changed since the denial? _____
_____

☐Yes ☐No 5. Has anyone in your household been approved for HPE in the last calendar year or if there is anyone pregnant, has she been approved for HPE or BYB for this pregnancy?
If yes, who: _____

☐Yes ☐No 6. Is there any child in the household who has a parent who is absent from the home, unable to work due to an injury or illness, deceased, receives Unemployment Benefits, or works less than 100 hours per month.
If yes, list the child(ren)'s name(s): _____

☐Yes ☐No 7. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below.

Insurance Information	
Name(s) of individual(s) covered: _____	
Name of insurance company: _____	Phone: _____
Address of insurance company: _____	Group#: _____
Policyholder name: _____	Policy#: _____

8. Applying for continued medical benefits is not a requirement for HPE and BYB.
☐ By checking this box, I opt out of applying for continued medical benefits.

only check box if applicant does not want DWS to look at ongoing medical assistance.

8

- Last Section (Page 10 of application):

I understand the State will use Social Security Numbers for those who are applying for benefits to make sure households are eligible for benefits. The State uses the State Income and Eligibility Verification System to do computer matches. The State uses the information it finds for benefit reviews and audits. The agencies that may receive, provide or use this information include: Workforce Services, Health, Human Services, Homeland Security, Social Security, and Internal Revenue Service. The State may also use information from consumer reporting agencies. The State may ask for information from banks or credit unions, and other organizations or people who may have eligibility information about my household. I must give the State proof that shows my household is eligible.

D03417000011021

I, (print name) _____, have read the statements above or someone has read them to me. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know I may be subject to federal or state penalties if I give false or untrue information. Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form, attached to this application.

M RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

N VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

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Appendix B: Presumptive Eligibility Determination Form (example of how to complete)

DWS-ESD 40

Rev. 04/2017

D11517900310101

Presumptive Eligibility Determination Form

Please complete one form for each presumptive eligibility application.

Name of PE Site: Site where you are doing the determination

Name of PE Worker: Your first and last name

Date of PE Determination: Date you approve or deny application

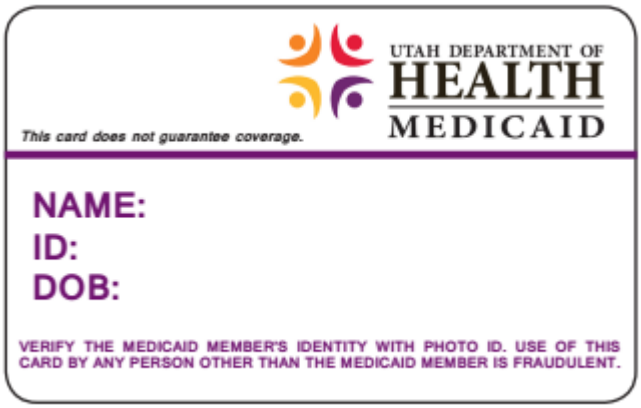
Name of Individual	PE Program	Approved/Denied	Denial Reason
Pregnant mom	BYB		

Equal Opportunity Employer Program

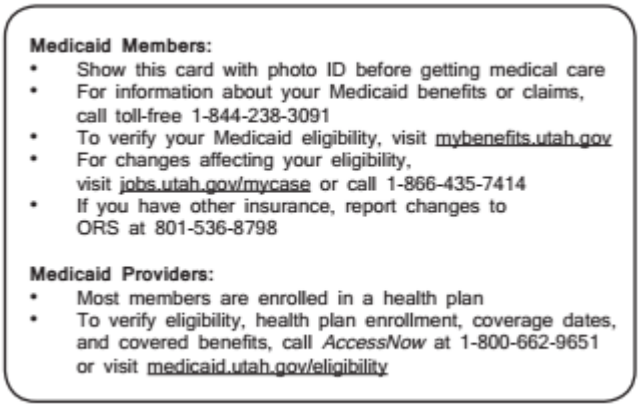
Auxiliary aids anc services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

Appendix C: Medical Identification Card

Front of card:



Back of card:



Appendix D: **172 Hour Chart**

Use this chart when an client is paid monthly or twice per month.

When using the 172 hour chart, find the weekly hours the client states they work in the column on the left. This will determine the monthly hours as shown in the right column in order to calculate the monthly gross income.

Average Hours Worked Per Week	Monthly Hours
40	172
39	169
38	163
37	160
36	155
35	151
34	146
33	143
32	138
31	134
30	129
29	126
28	120
27	117
26	112
25	108
24	103
23	100
22	95
21	91
20	86
19	83
18	77
17	74
16	69
15	65
14	60
13	57
12	52
11	48
10	43
9	40
8	34
7	31
6	26
5	22
4	17
3	14
2	9
1	5

Appendix E: Income Chart

- **Income Chart: Monthly Maximum Income Levels for BYB**
  ***Income guidelines are updated annually. DOH will email an updated income chart every year to all BYB Providers. Be sure to use the most updated version.**
  Utilizing the household size listed on the application, determine the monthly income allowable for that family size to qualify for Baby Your Baby.

Effective March 1, 2019

HH size	BABY YOUR BABY
	139% FPL Monthly gross income
2	1959
3	2471
4	2983
5	3495
6	4007
7	4519
8	5031
9	5543
10	6055